FRONT RANGE
EYE PHYSICIANS
205 S. Main St., Suite D - Longmont CO 80501
Phone: (303) 772-3611

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

As required by the Health Insurance Portability and Accountability Act (HIPAA) 1996

*I understand that Front Range Eye Physicians PC may not use or disclose my health information, except as noted in our Privacy Statement, without my written authorization.
*I understand that signing this authorization is voluntary and that if I refuse to sign this form it will not prevent my receipt of health care or eligibility for benefits under a health plan.
*I understand that if the organization or individual authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
*I understand that information disclosed here may be re-disclosed to additional parties and no longer protected.
*I understand that I may revoke this authorization in writing at any time, except where releases have already been made based upon my original permission.
*I understand that I am entitled to receive a copy of this form upon signing it. *This authorization expires 1 year after date of signature or when revoked in writing as above.*

***I hereby authorize the use and disclosure of my individually identifiable health information as described below.**

_____ _____
Patient Name **Date of Birth**

I authorize ☐ all of my health information OR ☐ some of my health information as described below:

***the period of healthcare from (date) _____ to (date) _____**

Person or organization authorized to release my health information: **Front Range Eye Physicians, PC**

Person or organization authorized to receive my health information:

_____	_____	_____
Name	Phone Number	Relationship
_____	_____	_____
Name	Phone Number	Relationship
_____	_____	_____
Name	Phone Number	Relationship

_____
Signature **Date**

(If signed by a patient representative):

_____
Representative Name (print) **Relationship to Patient & Authority Status**